YU'S ACUPUNCTURE & HERB CENTER

New Patient Information Questionnaire

Patient Name ____ Sex: __M, __F
First MI Last

Date of Birth ______/_____/_________ Height ____________________ Weight ____________________

Occupation: ________________________________ Marital Status: ____Single, ____ Married, ____Other

Phone (Day) (_________)_________-____________ Phone (Evening) (__________)_________-___________

Phone (Cell Opt.) (__________)________-________ E-mail (Opt.) ___________________________________

Home Address: ____

City ____ State ________________ Zip ___________________

Family Physician ______________________________ Phone (__________)_________-__________________

Referred by _________________________________ Phone (__________)_________-__________________

Emergency Information *(Please indicate who to notify in case of emergency)*

Name ______________________________________ Phone (H) (__________)_________-_____________

Relationship _________________________________ Phone (W/ C) (_______)_________-_____________

Insurance Information

Insurance _____________________________________ 2nd Insurance__________________________________

Plan Name: ___________________________________ Plan Name: ___________________________________

Policy No. _______________________________ Policy No.: _________________________________

Group No.: _______________________________ Group No.: __________________________________

Phone (_________)_________-__________________ Phone (_________)_________-__________________

Subscriber's Name ____________________________ Subscriber's Name ___________________________

Date of Birth ____/____/______, Sex: ___M, ___F Date of Birth ____/____/_____, Sex: ___M, ___F

Subscriber's Employer or School ____

Patient's Relationship to Subscriber: _____Self, _____Spouse, _____Child, _____Other

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with: ____, and assign directly to Yu's Acupuncture & Herb Center all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ___________________ Relationship: ___________ Date: ____________

YU'S ACUPUNCTURE & HERB CENTER

Confidential Patient Health History

Patient's Name____ **Date** ___________________________

Chief Complaint(s): *Please indicate how long you've had the condition(s).*

Other Complaint(s): *Please indicate how long you've had the condition(s).*

What kinds of treatments have you received?

Past Medical History:

List any Hospitalizations & Surgeries	Date	Place

List medications being taken (include dose)

____
____
____
____
____
____
____

Nutritional Supplements

____

____

____

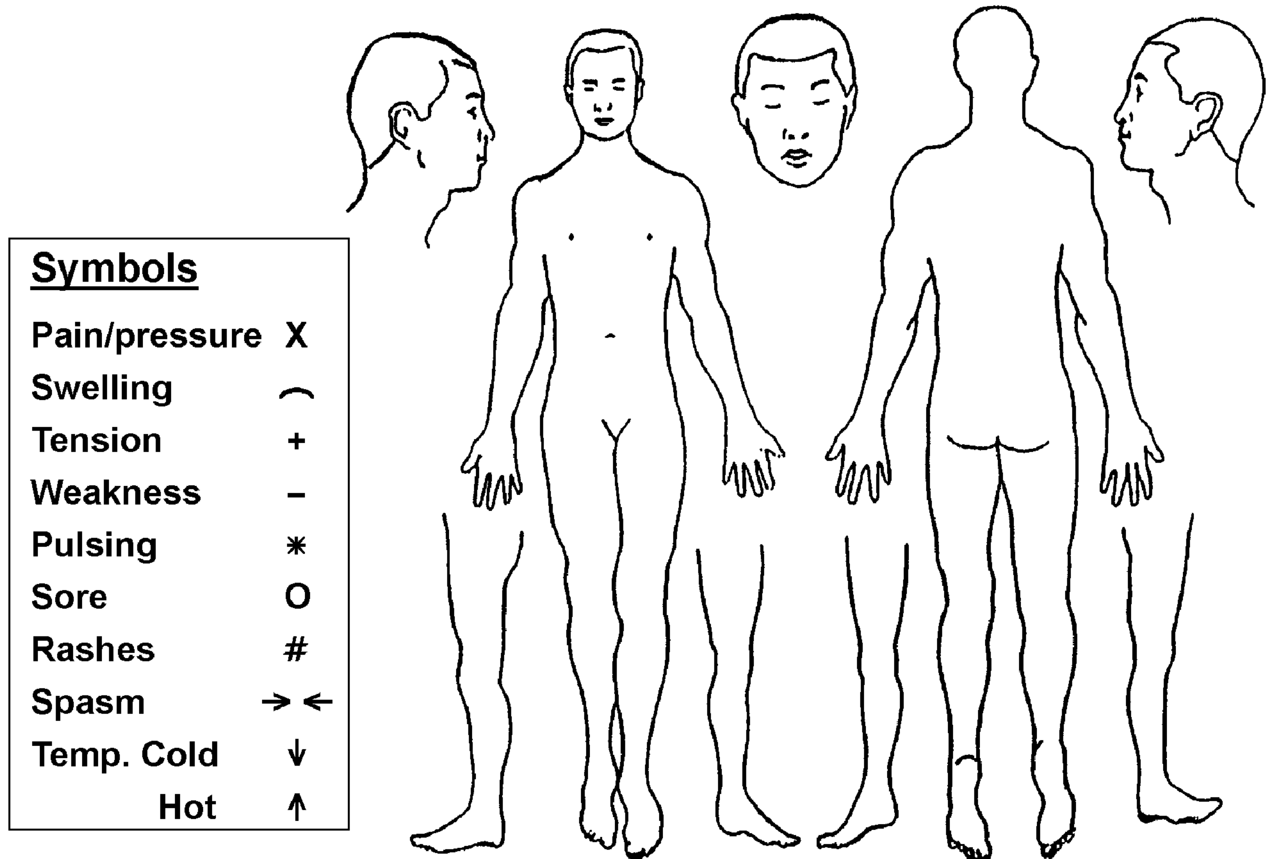
____

____

____

____

Indicate painful or distressed areas:



Please check if you have had:

General

[] Anemia
[] Fatigue
[] Fever
[] Weight Loss
[] Sweats
[] Chills
[] Drug Addiction

[] Poor Appetite
[] Localized Weakness
[] Bleed or Bruise Easily
[] Peculiar Tastes or Smells
[] Strong Thirst (hot or cold drinks)
[] Sudden Energy Drop
[] Poor Sleep Habits

[] Tremors
[] Poor Balance
[] Cravings
[] Weight Gain
[] Alcoholism
[] Tetanus Shot
[] Frequent cold/flu

Skin and Hair

[] Rashes
[] Itching
[] Dandruff
[] Change in hair/skin texture
[] Ulcerations
[] Eczema
[] Open sore
[] Acne
[] Corns
[] Warts
[] Psoriasis
[] Shingles (herpes zoster)
[] Recent moles
[] Loss of Hair
[] Hives
[] Nail Problems
[] Dry skin

Head, Eyes, Ears, Nose and Throat

[] Dizziness/Vertigo
[] Poor Vision
[] Cataracts
[] Ringing in ears
[] Sinus Problems
[] Grinding Teeth
[] Nasal Congestion
[] Headaches
[] Concussions
[] Eye Strain
[] Night Blindness
[] Blurry Vision
[] Poor Hearing
[] Nose Bleeds
[] Hoarseness
[] Migraines
[] Eye Pain
[] Color Blindness
[] Earaches
[] Spots in front of eyes
[] Recurrent Sore Throats
[] Facial Pain

Cardiovascular

[] High Blood Pressure
[] Low Blood Pressure
[] Chest Pain
[] Varicose Veins
[] Swelling of Hands/Feet
[] Fainting
[] Myocarditis
[] Difficulty in Breathing
[] Hardening of Arteries
[] Phlebitis
[] Blood Clots
[] Cold hands/feet
[] Coronary Heart Disease
[] Palpitations
[] Irregular Heartbeat
[] Mitral Stenosis
[] Mitral Prolapse
[] Bleeding easily

Respiratory

[] Cough
[] Bronchitis
[] Difficulty breathing lying down
[] Emphysema
[] Coughing Blood
[] Pneumonia
[] Asthma
[] Pain w/ deep breath
[] Production of Phlegm
[] Pleurisy

Gastrointestinal

[] Nausea
[] Vomiting
[] Bad Breath
[] Abdominal Pain or Cramps
[] Indigestion
[] Ulcer
[] Constipation
[] Gas/Bloating
[] Blood in Stools
[] Rectal Pain
[] Chronic Laxative Use
[] Colitis
[] Diarrhea
[] Belching
[] Black Stools
[] Hemorrhoids
[] Acid Reflux
[] Vomiting/Spitting blood

Genitourinary

[] Bed Wetting
[] Urgent Urination
[] Bladder Infections
[] Prostate Problems
[] Blood in Urine
[] Kidney Infections / Stones
[] Genital Herpes
[] Cystitis
[] Frequent Urination
[] Painful Urination
[] Venereal Disease
[] Incontinence

Pregnancy and Gynecology

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[] Use of Birth Control
[] Frequent changes in emotion
[] Hot Flash/Night Sweats
[] Osteoporosis
[ ] Age at 1st Menstruation
____ Time between Menstruation
____ Duration of Menstruation
____ First Date of Last Menstruation
[] Irregular Periods
[] Endometriosis
[] Uterine Fibroids
____ Age of Menopause
[] Menstrual Flow (heavy/light)
[] Color of Menses
[] Texture of Menses
[] Breast Lumps
[] Painful Periods/Cramps
[] Vaginal Discharge (Color)
[] Vaginal Sores

Musculoskeletal

[] Neck Pain
[] Muscle Weakness
[] Hand/Wrist Pain
[] Foot/Ankle Pain
[] Back Pain
[] Shoulder Pain
[] Hip Pain
[] Muscle Pains
[] Elbow Pain
[] Knee Pain

Neuropsychological

[] Seizures
[] Areas of Numbness
[] Concussion
[] Bad Temper
[] Difficulty Concentrating
[] Dizziness
[] Lack of Coordination
[] Depression
[] Easily susceptible to stress
[] Loss of Balance
[] Poor Memory
[] Anxiety
[] ADD

Infection

[] Measles
[] Rheumatic Fever
[] Malaria
[] Small Pox
[] Mumps
[] Tuberculosis
[] Chicken Pox
[] Whopping Cough
[] Typhoid Fever
[] Scarlet Fever

Others

Are you allergic to any of the following? (If yes, please specify)

( ) Medicine
( ) Food
( ) Herbs
( ) Others

Did you have or are you having any of the following?

( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Severe Bleeding Disorders
( ) Pregnant
( ) HIV Positive
( ) Hepatitis A/B/C
( ) Others

Social History

	No	Yes	When Started	When Stopped	Amount
Coffee	___	___	____________________	____________________	______
Tea	___	___	____________________	____________________	______
Alcohol	___	___	____________________	____________________	______
Tobacco	___	___	____________________	____________________	______
Other	___	___	____________________	____________________	______

Diet, Exercises and Life Style:

Family History (please include the relationship)

[] Migraines	____________________	[] Stroke	____________________
[] Heart Disease	____________________	[] High Blood Pressure	____________________
[] Allergies	____________________	[] Mental Illness	____________________
[] Asthma	____________________	[] Gall Stones	____________________
[] Arthritis	____________________	[] Cancer	____________________
[] Diabetes	____________________	[] Thyroid Disease	____________________
[] Glaucoma	____________________	[] Epilepsy	____________________
[] Others	____________________		

Comments

Please tell us of any other problems you would like to discuss:

____
____
____
____
____
____
____

Please inform us if you have
Bleeding Disorders or *Pacemakers* or your are *Pregnant*
prior to receiving treatments!